



**Texas Department of Insurance, Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

**PART I: GENERAL INFORMATION**

Requestor's Name and Address:  HARRIS METHODIST HOSPITAL FT. WORTH 3255 W. PIONEER PKWY ARLINGTON, TX 76013	MFDR Tracking #: M4-09-A599-01
Respondent Name and Box #:  FEDERAL INSURANCE CO. REP. BOX #: 17	

**PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION**

Requestor's Position Summary: "Since TDI moved to a 200% of MAR for outpatient services on 3/1/08 for hospital claims, we have reviewed the Medicare allowance and decided the insurance reimbursement does not meet this criteria. Medicare would have allowed this facility 182.60 for the line item listed for the MAR at 200%. Based on their payment of 00, a supplemental payment of \$182.60 is due. We request they pay the amount due of \$182.60..."

Principle Documentation:

1. DWC 60 package
2. Hospital or Medical Bills
3. EOBs
4. Medical Reports
5. Total Amount Sought \$182.60

**PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION**

Respondent's Position Summary: "...This date of service was paid based upon the medicare [sic] reimbursement plus the percentage increase specific to this case. One CPT code was not reimbursed, 76376, as it was not a covered charge. The CT scan was correctly reimbursed. Therefore, the Provider has been correctly paid and is owed no additional reimbursement..."

Principle Documentation:

1. DWC 60 package

**PART IV: SUMMARY OF FINDINGS**

Date(s) of Service	Services in Dispute	Calculation	Amount in Dispute	Amount Due
09/07/2008	Hospital Outpatient Services CPT Code 76376	Requestor is seeking a line item review of CPT Code 76376 only.	\$182.60	\$0.00
Total Due:				\$0.00

**PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION**

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, effective for medical services provided in an outpatient acute care hospital on or after March 1, 2008, set out the reimbursement guidelines for Hospital outpatient services.

This dispute was filed in the form and manner as prescribed by 28 TAC §133.307 and is eligible for Medical Dispute Resolution under 28 TAC §133.305 (a)(4).

1. The services listed in Part IV of this decision were denied or reduced by the Respondent with the following reason codes:  
Explanation of benefits with the listed date of audit 11/05/2008:
  - 96 – Non-covered charge(s).Explanation of benefits with the listed date of audit 03/15/2009:
  - 96 – Non-covered charge(s).
2. Rule 134.403 (e) states in pertinent part, “Regardless of billed amount, reimbursement shall be:
  - (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or
  - (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables;”
3. Pursuant to Rule §134.403(f), “The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register*. The following minimal modifications shall be applied.
  - (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
    - (A) 200 percent; unless
    - (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.
4. Under the Medicare Outpatient Prospective Payment System (OPPS), all services paid under OPPS are classified into groups called Ambulatory Payment Classifications or APCs. Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC for an encounter. Within each APC, payment for ancillary and supportive items and services is packaged into payment for the primary independent service. Separate payments are not made for a packaged service, which is considered an integral part of another service that is paid under OPPS. An OPPS payment status indicator is assigned to every HCPCS code. Status codes are proposed and finalized by Medicare periodically. The status indicator for each HCPCS codes is shown in OPPS Addendum B which is publicly available through the Centers for Medicare and Medicaid services. A full list of status indicators and their definitions is published in Addendum D1 of the OPPS proposed and final rules each year which is also publicly available through the Centers for Medicare and Medicaid services.
5. Upon review of the documentation submitted by the Requestor and Respondent, the Division finds that:
  - (1) No contract exists;
  - (2) MAR can be established for these services; and
  - (3) Separate reimbursement for implantables was *NOT* requested by the requestor.
6. The requestor is seeking reimbursement for CPT Code 76376. This particular CPT Code has a payment status code of “N.” Status code indicator “N” is defined as “Items and services packaged into APC rates. Paid under OPPS; payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.” Reimbursement cannot be recommended for this code.
7. Based upon the documentation submitted by the parties and in accordance with Texas Labor Code Sec. 413.031 (c), the Division concludes that the requestor is not due additional payment.

#### **PART VI: GENERAL PAYMENT POLICIES/REFERENCES**

Texas Labor Code Sec. 413.011(a-d), 413.031 and 413.0311  
28 TAC Rule §134.403  
28 TAC Rule §133.305  
28 TAC Rule §133.307

**PART VII: DIVISION DECISION**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to \$0.00 reimbursement.

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
Date

**PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL**

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**